

Bailey House Client Care Management Model

BAILEY HOUSE HAS A DEMONSTRATED TRACK RECORD IN ENGAGING HARD-TO-REACH POPULATIONS INCLUDING PEOPLE WITH HISTORIES OF HOMELESSNESS, INCARCERATION, SUBSTANCE USE, AND/OR MENTAL ILLNESS AND RE-CONNECTING THEM TO THE CARE THEY NEED WITHIN A STABLE HOUSING ENVIRONMENT.

ELEMENTS OF TRAUMA-INFORMED SERVICES WITHIN A CLIENT CENTERED CARE MODEL

SINGLE POINT-OF-ENTRY

Centralized intake and assessments i.e. depression screening, trauma assessment, etc.

The service team is a gateway to on- and off-site services

All services are centrally coordinated

INDIVIDUALIZED COMPREHENSIVE CARE PLAN

Developed in collaboration with individual client

Focuses on medical and mental health, housing, substance use/harm reduction and home care needs

Plan addresses treatment adherence and health literacy needs

ASSIGNMENT TO SPECIALIZED CARE MANAGEMENT TEAM

Team composed of Care Coordinator, Patient Navigator and Community Resource Specialists

Individuals are assigned to a trauma-informed team with expertise in medical care, housing, mental health, substance use/harm reduction, and re-entry

Collaborate with health providers to ensure coordination of care

Provide intensive outreach/in-reach to locate and maintain in care

Provide translation services as needed

LINKAGE TO APPROPRIATE COMMUNITY BASED PROVIDERS

Bailey House has an established network of providers:

15 community health centers/FQHC's

5 hospitals

6 outpatient substance use programs

5 inpatient rehabilitation programs

13 outpatient mental health clinics

3 harm reduction service providers including syringe exchange